AccuReview

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[Date notice sent to all parties]: December 3, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar ESI L5/S1

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

This physician is Board Certified in Orthopaedic Surgery with over 15 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The claimant is a male with a reported work related back injury on XX/XX/XX. This injury was a result of digging hole with shovel, causing pain in low back, back stiffness, decreased spinal ROM, decreased flexion, decreased extension, decreased lateral bending and decreased rotation. The pain is located in the low back bilaterally, in the mid-lumbar bilaterally. The pain radiates down left leg. Pain was described as sharp in nature.

10-24-13: MRI Lumbar w/out. Impression: 1. Disc desiccation from L3-4 through L5-S1. 2. Left paracentral disc bulge at L3-4 with minor narrowing of the central canal. 3. Moderate central canal stenosis at L4-5 with a central disc protrusion and 5.5mm inferior migration of disc material on the left that contacts the thecal sac and left L5 nerve root. Moderate left subarticular zone narrowing. 4. Right paracentral disc bulge at L5-S1 that mildly displaces the right S1 nerve root. Early facet hypertrophic changes with mild right neural foraminal narrowing. Mild right subarticular zone narrowing.

01-14-14: SOAP Note. S: Claimant indicated that he was no longer doing spinal rehabilitative exercises anymore; stopped by insurance. He continued with the same history and clinical findings. He tried to duty light duty, but there is none due to his job consisting of heavy labor which certainly aggravated his back condition. O: After electrical studies, there is evidence of an ongoing bilateral L5 and S1 nerve root denervation process (two level nerve root abnormalities). A: Claimant has significant spinal mechanical problems. Recommend continuing spinal rehabilitation exercises, xxxxxx, and eventually he can do them at home. He should learn biomechanics of such exercises though. Ergonomic instructions were given. The Medrol did help some in terms of pain relief, but it is back up again. Therefore, at this point recommend the following: P: 1. Claimant should not do physical activities at work, light duty

can be attempted. However, recommendations should be honored at work. 2. Consider ESI. 3. Continue rehabilitative program under your supervision. 4. F/U in 6 weeks. 5. Hydrocodone and gabapentin refilled.

01-14-14: Bilateral Lower Extremity NCV and EMG Study Report. Impression: Neuroelectrophysiologic findings are consistent with bilateral L5 and S1 (two levels) nerve root denervation process (radiculopathy).

03-05-14: ESI Lumbar. Pre-Impression: There is loss of disk space height at L5-S1. There appears to be slightly shortened interpedicular diameters from the L3-4 to the L5-S1 level which may be due to developmental spinal canal narrowing. Post-Impression: The claimant has lower extremity pain radiating to the left greater than right lower extremity due to multilevel disk displacement. The claimant had significant relief following the anesthesia phase of the initial lumbar ESI injection today. The claimant will be monitored and scheduled for his follow-up therapeutic ESI injection within the next two weeks. CT of the Lumbar spine post ESI with contrast enhancement: Impression: At L3-4 and L5-S1, there is a 3mm broad-based soft tissue disk protrusion which is central and to the left midline at L3-4 and central and to the right of the midline at L5-S1. Borderline spinal canal stenosis in noted at L5-S1. Bilateral, right greater than left foraminal narrowing is noted at L5-S1. Bilateral foraminal narrowing is noted at L3-4. At L4-5, there is a 3mm to 4mm central soft tissue disk protrusion effacing the thecal sac and extending 4mm below the interspace. The AP spinal canal diameter measures 7.7mm compatible with spinal canal stenosis. Bilateral foraminal narrowing is noted. The opacified injected therapeutic volume is demonstrated with coverage of the epidural space and designated foramen from the L3-4 to the L5-S1 level.

02-04-15: Operative Report. Preoperative Diagnoses: 1. L3-4, L4-5, L5-S1 herniated nucleus pulposus. 2. Bilateral lower extremity radiculopathy. Postoperative Diagnoses: 1. L3-4, L4-5, L5-S1 herniated nucleus pulposus. 2. Bilateral lower extremity radiculopathy.

04-21-15: MRI Cervical Spine w/o Contrast. Impression: Uncomplicated postsurgical changes with attached hardware identified at C5-6. Otherwise unremarkable non-contrast MR examination of the cervical spine.

07-08-15: MRI of the Lumbar Spine w/o and with Contrast. Impression: 1. Motion-degraded examination. 2. A number of surgical changes are identifiable on this examination spanning the L3-4 through L5-S1 levels. 3. Posterocentral inferior extruded tissue at L4-5. The absence of associated enhancement favors the presence of recurrent disc extrusion. Comparison with the pre-operative examination would be additionally useful in further understanding the potential relevance of this finding. It partially effaces the ventral epidural fat and contours the dural sac without marked dural sac deformity. 4. Broad right central, subarticular and proximal foraminal extrusion of disc material at L5-S1. This creates asymmetric narrowing of the spinal canal and deformity on the descending right S1 nerve root sleeve.

08-05-15: Transcription. CC: back pain. Claimant was told last month after MRI that he has reherniated the discs but the surgeon has released him and told him this is as good as he will get. Evidently he had a three level discectomy. He has continued pain in the left leg and which he had before but now has pain in both legs and has pain around the medial thighs as well. He also has left leg weakness and has a tingling and numb feeling in the leg. He is currently seeing pain management. PE: Musculoskeletal: Lumbosacral Spine: large surgical scar L spine. Tenderness: left paraspinal, right paraspinal, right sciatic notch and left sciatic notch. Flexion: AROM of 45 degrees and painful. Extension: AROM of 15 degrees and painful. Pain more on flexion. Special Tests: sLR sitting causes pain in the left leg to calf and also tingling feeling. Tight is negative touch “different” left thigh and lower leg compared to right. Has some weakness of the left EHL but not consistently. Heel walk had occ drop of the left foot but again not consistently. Pain in back on heel walk. Neurologic: deep tendon reflexes: 1+ left patella, 0 right ankle jerk and 0 left ankle jerk, 2+ right patella. Assessment: 1. Lumbar strain 847.2, 2. Post surgical complication 998.69, 3. Low back pain 724.4. Plan: Neurosurgery referral ordered for low back pain, lumbar strain, post surgical complication.

09-10-15: Office Visit CC: continued back pain. ROS: weight gain of more than 10 pounds, night sweats; reported chest pain; reported pain with urination; reported shoulder pain, hip pain, muscles weakness; reported sleep disturbances. PE: Spinal Examination: There is significant spinal tenderness in the paraspinal muscles. Bilateral SLR is positive. Reflexes in upper and lower extremities are normal at 2 out of 4. The claimant demonstrated limited ROM

with flexion, extension, side bending and rotation. Spinal motion is with pain. Assessment: Claimant complained of low back pain and lower extremity pain secondary to herniated disc pulposis, L4-5 and L5-S1. These are recurrent herniation as claimant has had previous decompression at these 2 levels. Recommend a trial with ESI. If the ESI fails to relieve his pain and radiculopathy, next consideration would be for surgical decompression of recurrent herniated disc at L4-5 and L5-S1. Problem's added in today's visit: Sciatica 724.3, Low Back Pain 724.2.

09-23-15: UR. Reason for denial: Non-certify caudal ESI since there is lack of clinical information. Other than a vague "positive" SLR of bilateral lower extremities, there is no objective findings of radiculopathy correlating with paraphrased findings on imaging studies. In fact there is no submission of the lumbar MRI report. There is also question as to any recent electrodiagnostic study to assist in documentation of radiculopathy. Work up is particularly pertinent in this case given reported previous multilevel surgical procedure of a "3 level discectomy, "and reported consideration of a repeat surgery. That in turn, begs the question as to the results of pending neurosurgical consult, and question as to the diffuse approach of a CAUDAL ESI as opposed to a Transforaminal, more diagnostic as well as therapeutic approach, to assist in assessment regarding additional surgery. There is also question as to Review of Systems positive for "pain on urination, "and whether there has been any consideration of other pain generators for low back pain other than radiculopathy – particularly genitourinary. There is also question as to more recent conservative measures including physical therapy, compliant home exercise program, medications (with none documented on submitted records) and activity modification prior to progressing to more invasive procedures.

10-20-15: MRI Spine Lumbar w/o Contrast. Impression: 1. Post surgical changes from L3-S1 with multifocal signal abnormality predominantly involving lateral recess as described above, while can be seen with postsurgical changes, superimposed recurrent or residual disc protrusion not excluded. Postcontrast images can be helpful.

10-20-15: Office Visit. CC: LBP. Claimant went to the ER due to severe pain and inability to urinate with pain radiating down his left leg. He has had left leg pain, but it has been worsening his symptoms. HE also stated that now his leg is giving out on him, causing him to fall in the shower this morning. Medications: zanaflex, norco. Allergy: naproxen (critical). Assessment: Claimant has paresthesias, appears to be L4, possibly L5 dermatome on the left side. Deep tendon reflexes are ¼ on the left and 2/4 on the right. HE has slightly positive SLR on the right side, but significantly positive SLR on the left side. Plan: At this point, claimant is now using a wheelchair to get around and because his leg is giving out on him. Recommend due to change in symptoms, that we get a stat MRI of his lumbar spine with contrast. Prescriptions given for Norco 7.5, Zanaflex, and Celebrex. Problems added in today's visit: Sciatica 724.3, Low Back Pain 724.2.

10-21-15: MRI Spine Lumbar w/o Contrast. Impression: Post surgical changes as described above with suspicion for recurrent or residual disc protrusion especially at L3/4 level on the left side with narrowing of the left lateral recess, clinical correlation recommended for left L4 radiculopathy. Additional residual or recurrent disc bulge/protrusion also noted at L4/5 and L5/S1 as described above.

10-22-15: Office Visit. CC: LBP with worsening severe pain and symptoms that were worsening into his primarily the left leg. Medicaitons: Zanaflex and Norco. MRI Review: Demonstrated that the claimant does have a disk herniation at L3-4 causing significant compression of the L4 nerve root on the left side. It is consistent with the radicular pain that he is having down the L4 nerve root on the left leg. He also has paresthesias associated with this weakness. Assessment: Claimant is not working at this point and does not feel he can work. Given the problem that he has here, he may need to have surgery for this to decompress the L3-4 nerve root. He also has some scar tissue at previous laminectomy and laminotomy there, but he may have recurrent herniation that is causing this problem. Given the option to try an ESI versus surgery, he is opting for ESI. Plan: ESI, if no improvement, recommend consideration of decompressing the L3-4 segment.

11-16-15: UR. Reason for denial: Within the associated medical file, there is documentation of a previous adverse determination rendered due to lack of documentation of objective findings of radiculopathy correlating with paraphrased on imaging studies, a lumbar MRI report, and recent conservative measures. In addition, there is documentation of a plan identifying that claimant complaints of low back pain and lower extremity pain secondary to herniated disc pulposis, L4-5 and L5-S1 and a recommendation for a trial of ESI, levels: Caudal. Furthermore, there is

documentation of imaging (MRI) findings (nerve root compression) at the L5-S1 level. However, despite nonspecific documentation of subjective findings (low back pain that radiates down both legs), there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, or tingling) radicular findings in each of the requested nerve root distributions. In addition, despite documentation of objective findings (positive bilateral SLR), the prior adverse determination's concern for lack of documentation of objective findings of radiculopathy correlating with paraphrased findings on imaging studies, has not met. Furthermore, given documentation of imaging findings (posterocentral inferior extruded tissue at L4-5, MILD concentric narrowing of the spinal canal, MILD bilateral narrowing of the neural foramina), there is no documentation of imaging (MRI) findings (MODERATE or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the L4-5 level. Moreover, given no documentation of failure of conservative treatment (activity modification, medications, and physical modalities); the prior adverse determination's concern for lack of documentation of recent conservative measures, has not been met. Lastly, there is no documentation of a Discussion/Rationale as to why such may not be applicable. Therefore, certification of the requested Appeal: Lumbar ESI 1% is not recommended.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The request for L5-S1 lumbar epidural steroid injection (ESI) is denied. The claimant remains symptomatic following a multilevel lumbar decompression. He has had acute worsening of his left leg symptoms. The recent MRI of the lumbar spine demonstrates recurrent disc herniation at L3-4, consistent with possible left L4 radiculopathy. The medical record does not indicate any objective findings on examination that are specifically associated with a L4 radiculopathy. Before any spinal injections are considered, the level of the radiculopathy should be confirmed by an EMG-NC study. This is especially important in a patient who has had a decompression of multiple spinal levels. Once there is electrodiagnostic evidence of L4 radiculopathy, an injection closer to the site of pathology is preferable to an injection at L5-S1. Therefore, after reviewing the medical records and documentation provided, there is no medical necessity for request of Lumbar ESI L5/S1 and is denied.

Per ODG:

Steroid injections	**Criteria for Steroid injections:** · Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; · Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; · Pain interferes with functional activities (eg, pain with elevation is significantly limiting work); · Intended for short-term control of symptoms to resume conservative medical management; · Generally performed without fluoroscopic or ultrasound guidance; · Only one injection should be scheduled to start, rather than a series of three; · A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; · With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; · The number of injections should be limited to three.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**